The Psychology Offices
of
Barbara Alyne Serko, Psy.D.
FLA. LIC. # PY0003103

April 28, 1997

To Whom It May Concern:

Anthony Bayad first came to see me on January 15, 1997. After an initial evaluation I found him to be suffering from an Adjustment Disorder with anxiety and depressed mood, as a result of work related issues.

It is my opinion that Mr. Bayad is presently unable to work and that he has been so disabled since January 23, 1997.

Sincerely,

Barbara A. Serko, Psy.D.
Licensed Psychologist

2601 E. OAKLAND PARK BLVD. SUITE 201, FT. LAUDERDALE, FLORIDA 33306 • PHONE (305) 564-2021

[redacted]

HEALTH INSURANCE CLAIM FORM

OMB NO 0938 0008

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO) ☐ MEDICAID (MEDICAID NO) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO) ☐ FECA BLK LUNG (SSN) ☒ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2 PATIENT'S DATE OF BIRTH	3 INSURED'S NAME (LAST NAME FIRST NAME MIDDLE INITIAL)
Anthony Bowers	07 16 71	Anthony Bowers
4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 2900 NE 30 st 10F Fort Lauderdale FL 33306 TELEPHONE NO 954 565-0344	5 PATIENT'S SEX MALE ☒ FEMALE ☐	6 INSURED'S I.D. NO (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS) 021686333 01
	7 PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8 INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO) 2516968/BCXQ-01 ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	10 WAS CONDITION RELATED TO a PATIENT'S EMPLOYMENT YES ☐ NO ☐ b ACCIDENT AUTO ☐ OTHER ☐	11 INSURED'S ADDRESS (STREET CITY STATE ZIP CODE) same as #4 TELEPHONE NO 11a CHAMPUS SPONSOR'S STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED BRANCH OF SERVICE
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW SIGNED [signature] DATE 12/15/97		13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (INSURED OR AUTHORIZED PERSON) [signature]

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE DATES	16a IF EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (# PUBLIC HEALTH AGENCY)	20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED	DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (# OTHER THAN HOME OR OFFICE)	22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES
Doctor's Office	

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC OR DX CODE

1 309.28 DSM IV
2
3
4

24 EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐

PRIOR AUTHORIZATION NO Case # 9701156036

24 A DATE OF SERVICE FROM TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G # OF	H LEAVE BLANK
01-15-97	3	90801	Diagnostic Interview	1.	75 00	1hr		
01/22/97	"	90844	Ind. Psychotherapy	"	70 00	"		
01/29/97	"	"	"	"	70 00	"		
02/05/97	"	"	"	"	70 00	"		
02/12/97	"	"	"	"	70 00	"		

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS) I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF	26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐	27 TOTAL CHARGE 355 00	28 AMOUNT PAID -0-	29 BALANCE DUE $355.00
Barbara Serko, Psy.D.	30 YOUR SOCIAL SECURITY NO 049-24-2825	31 PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO 954-564-2021 BARBARA A. SERKO, Psy. D. 2601 E. Oakland Park Blvd, Suite 201 Ft. Lauderdale, Florida 33306		
DATE 12-17-97				
32 YOUR PATIENT'S ACCOUNT NO n/a	33 YOUR EMPLOYER I.D. NO 65-0634955	I.D. NO PY0003103		

* PLACE OF SERVICE AND TYPE OF SERVICE (P O S) CODES ON THE BACK REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/91

Form HCFA-1500 (1-84) Form CHAMPUS-501 Form OWCP-1500 Form RRB-1500

AT&T

CIGNA HealthCare of Florida

CIGNA HealthCare

COPAYS 10 DR VISIT 40 EMERGENCY 0 HOSPITAL

ID # 021686333 01 GROUP 2616068/BCXQ-01

PCP CALL MEMBER SERVICES
NAME ANTHONY BAYAD

MRN 0050864001 MEMBER SERVICES:1-800-664-4266
MENTAL HEALTH/CHEMICAL DEPENDENCY:1-800-695-0090
Medical Claims To: PO BOX 6201, LONDON, KY 40742-6201 GEN AT&T

1-800-695-0090 x 9 x 2015 #
— Christy —

Case # 9701156036
10 sessions (+9 more?)

90801 - 75.00
90844 - 70.00 for 9 sessions
after sessions
called 840 No pay. 60.

Claims:
MBC
attn: Lucent Claims
PO Box 1837
Maryland Heights, MO
63043

021-68-6333-01
309.28

STATEMENT

Cigna

BARBARA A. SERKO, Psy. D.
2601 E. Oakland Park Blvd, Suite 201
Ft. Lauderdale, Florida 33306

CHARGES OR PAYMENTS MADE AFTER LAST DATE SHOWN WILL APPEAR ON YOUR NEXT STATEMENT

Anthony Bayad
2900 NE 30 St 10F
Ft. Lauderdale, FL
33306

BALANCE FORWARD

FAMILY MEMBER	DATE	DETAIL		CHARGES		PAYMENTS		BALANCE	
	1/15/97	90801	✓	75	00	—		75	00
	1/22/97	90844	✓	70	—	—		145	—
	1/29/97	"	✓	70	—	—		215	—
	2/5/97	"		70	—	—		285	—
2-17-97 Ins.	2/12/97	"		70	—	—		355	—
	2/19/97	"		70	—	—		425	—
	2/26/97	"		70	—	—		495	—
	3/24/97	ins pd.		—		215	—	280	—

SAFEGUARD BUSINESS SYSTEMS Form No. LS-M2-WD

PLEASE PAY LAST AMOUNT IN BALANCE COLUMN

Payment is required at the time services are rendered unless other arrangements are made with the business office. If psychological or neuro-psychological testing is required, there will be an additional fee for the testing procedure.

We do accept insurance payments sent directly to this office from the insurance company. You are however, responsible for the co-payment and deductible at the time of service. If for any reason your insurance does not pay this office, you will be responsible to pay all charges within 30 days of notice of non-payment from the insurance company.

I hereby acknowledge responsibility for all charges incurred by Cigna healthcare to Barbara SERKO, 2601 E. Oakland Park Blvd., Suite 201 Ft. Lauderdale, Fl. 33306

01-13/97
DATE

SIGN

AUTHORIZATION TO FURNISH INFORMATION

I authorize and request _____

to furnish to _____

all information concerning my case history and treatment, examinations or hospitalization which I received, including copies of hospital, medical and psychological records.

_____ _____
DATE SIGN

_____
WITNESS